House File 2474 - Introduced

HOUSE FILE _____
BY UPMEYER

Passed House, Date _____ Passed Senate, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

An Act relating to chronic care management.
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
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Section 1. NEW SECTION. 135.158 DEFINITIONS.
For the purpose of this division, unless the context otherwise requires:
1. "Chronic care" means health services provided by a health care provider for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management to attempt to restore the individual to highest function, minimize the negative effects of the chronic condition, and prevent complications related to the chronic condition.
2. "Chronic care information system" means approved information technology to enhance the development and communication of information to be used in providing chronic care, including clinical, social, and economic outcomes of chronic care.
3. "Chronic care infrastructure" means the state's plan for chronic care infrastructure, prevention of chronic conditions, and a chronic care management program, and includes an integrated approach to patient self=management, community development, health care system and professional practice changes, and information technology initiatives.
4. "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self=care efforts, systemic supports for the physician and patient relationship, and a chronic care plan emphasizing prevention of complications utilizing evidence=based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
5. "Chronic care plan" means a plan of care between an individual and the individual's principal health care provider that emphasizes prevention of complications through patient empowerment including but not limited to providing incentives to engage patients in the patient's own care; and clinical, social, or other interventions designed to minimize the negative effects of the condition.
6. "Chronic care resources" means health care providers, advocacy groups, health departments, schools of public health and medicine, health plans and others with expertise in public health, health care delivery, health care financing, and health care research.
7. "Chronic condition" means an established clinical condition that is expected to last a year or more and that requires ongoing clinical management.
8. "Department" means the department of public health.
9. "Director" means the director of public health.
10. "Eligible individual" means a resident of the state who has been diagnosed with a chronic condition or is at an elevated risk for a chronic condition and who is a recipient of medical assistance or hawk=i program benefits, is a member of the expansion population pursuant to chapter 249J, or is an inmate of a correctional institution in the state.
11. "Health care provider" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide health care services

within the state.

12. "Health risk assessment" means screening by a health care provider for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.

13. "Prevention and chronic care partnership" means a regionally based consortium of health care providers and chronic care resources that promote the health of community residents and prevention of chronic conditions, develop and implement arrangements for delivering chronic care, develop significant patient self=care efforts, and provide systemic supports for the physician=patient relationship.

14. "State initiative for prevention and chronic care management" or "state initiative" means the state's plan for developing a chronic care infrastructure for prevention and chronic care management, including coordinating the efforts of health care providers and chronic care resources to promote the health of residents and the prevention and management of chronic conditions, developing and implementing arrangements for delivering prevention services and chronic care management, developing significant patient self=care efforts, providing systemic support for the health care provider=patient relationship and options for channeling chronic care resources and support to health care providers, providing for community outreach and education efforts, and coordinating information technology initiatives.

Sec. 2. NEW SECTION. 135.159 PREVENTION AND CHRONIC CARE MANAGEMENT INITIATIVE == ADVISORY COUNCIL.

1. The director, in collaboration with the prevention and chronic care management advisory council, shall develop a state initiative for prevention and chronic care management.

2. The director may accept grants and donations, and shall apply for any federal, state, or private grants available to fund the initiative. Any grants or donations received shall be placed in a separate fund in the state treasury and used exclusively for the initiative.

3. The director shall convene an advisory council to provide technical assistance to the director in developing a state initiative that integrates evidence=based prevention and chronic care management strategies into the public and private health care systems. The advisory council, at a minimum, shall include all of the following members:

a. The director of human services, or the director's designee.

b. The director of the department of elder affairs, or the director's designee.

c. The commissioner of insurance, or the commissioner's designee.

d. A representative of the Iowa medical society.

e. A representative of the Iowa hospital association.

f. A representative of health insurers.

g. A medical social worker or home care professional.

h. A patient advocate.

i. A primary care physician.

j. A pharmacist.

k. A specialist in public health and epidemiology.

l. An expert in health outcomes research.

m. A representative of an entity that is taking a leading role in health information technology.

4. The advisory council shall elicit input from a variety of health care providers, health care provider organizations, community and nonprofit groups, insurers, consumers, businesses, school districts, and state and local governments in developing the advisory council's recommendations.

5. The advisory council shall submit initial recommendations to the director for the prevention and chronic care management initiative no later than January 1, 2009. The recommendations shall address all of the following:

a. The recommended organizational structure, including the recommended size and geographic boundaries of the regions of the state to serve as territories, for the prevention and chronic care partnerships. The advisory council shall also prioritize one of these regions to be used as an initial pilot for a prevention and chronic care partnership.

b. A process for identifying leading health care providers and existing prevention and chronic care resources within the prevention and chronic care partnership regions identified and for consulting with these providers and resources.

c. A prioritization of the chronic conditions for which

prevention and chronic care management services shall be provided, taking into consideration the prevalence of specific chronic conditions and the factors that may lead to the development of chronic conditions, the fiscal impact to state health care programs of providing care for the chronic conditions of eligible individuals, the availability of workable, evidence=based approaches to chronic care, and public input into the selection process. The recommendation shall also include a timeline for inclusion of specific chronic conditions in the initiative.

d. A method to involve health care providers in identifying eligible patients, which includes but is not limited to the use of a uniform health risk assessment.

e. The methods for increasing communication between health care providers and patients, including patient education, self=management, and follow=up plans.

f. The educational, wellness, and clinical management protocols and tools to be used by health care providers, including management guideline materials for health care.

g. The use and development of process and outcome measures, aligned to the greatest extent possible with existing measures, to provide performance feedback for health care providers and information on the quality of care, including patient satisfaction and health status outcomes.

h. Payment methodologies to align reimbursements and create financial incentives and rewards for health care providers to utilize prevention services, establish management systems for chronic conditions, improve health outcomes, and improve the quality of care, including case management fees, payment for technical support and data entry associated with patient registries, and the cost of staff coordination within a medical practice.

i. Methods to involve public and private groups, health care providers, insurers, third=party administrators, associations, community and consumer groups, and other local entities to facilitate and sustain the initiative.

j. Alignment of any information technology needs with other health care information technology initiatives.

k. Methods to involve appropriate health resources and public health and outcomes researchers to develop and implement a sound basis for collecting data and evaluating the clinical, social, and economic impact of the initiative, including a determination of the impact on expenditures and prevalence and control of chronic conditions.

l. Elements of a marketing campaign that provides for public outreach and consumer education in promoting prevention and chronic care management strategies among health care providers, health insurers, and the public.

m. A method to periodically determine the percentage of health care providers who are participating, the success of the empowerment=of=patients approach, and any results of health outcomes of the patients participating.

6. The director of human services shall obtain any federal waivers or state plan amendments necessary to implement the prevention and chronic care management initiative within the medical assistance, hawk=i, and IowaCare populations.

7. Following submission of the initial recommendations by January 1, 2009, the director shall select one or more regions for deploying and evaluating a prevention and chronic care partnership pilot project. Following deployment of the initial pilot project, the director shall work with the department of human services, insurers, health care provider organizations, and consumers in implementing the initiative beyond the population of eligible individuals as an integral part of the health care delivery system in the state. The advisory council shall continue to review and make recommendations to the director regarding improvements in the initiative.

8. Each prevention and chronic care partnership shall do all of the following:

a. Select, based on the recommendations of the advisory council, the chronic conditions for which chronic care and prevention services will be provided within the region after considering the prevalence of the chronic condition in the region and factors that may lead to the development of chronic conditions, the fiscal impact to the state of providing care for the chronic condition for the eligible population, the availability of workable, evidence=based approaches to chronic care for the chronic condition, and any public input received.

b. Determine how to implement the prevention and chronic care services on a regional basis in a manner that

participating health care providers and chronic care resources support.

c. Develop a mechanism for health care providers and chronic care resources to participate in the partnership.

d. Identify and disseminate evidence=based information to participating health care providers and chronic care resources.

e. Assist in outreach programs to address chronic conditions.

f. Recommend mechanisms to provide incentives for participation by health care providers and chronic care resources.

g. Recommend and evaluate health information options to enhance the accuracy and efficiency of communications necessary to the delivery of chronic care.

h. Collect data as recommended by the advisory council and director to evaluate the clinical, social, and economic impact of the partnership.

EXPLANATION

This bill relates to prevention and chronic care management. The bill directs the director of public health, in collaboration with the prevention and chronic care management advisory council created in the bill, to develop a state initiative for prevention and chronic care management. The bill provides that the director may accept grants and donations, and shall apply for any federal, state, or private grants available to fund the initiative. Grants or donations received are to be placed in a separate fund in the state treasury and used exclusively for the initiative.

The bill directs the director of public health to convene an advisory council to provide technical assistance to the director in developing a state initiative that integrates evidence=based prevention and chronic care management strategies into the public and private health care systems. The bill specifies the membership of the advisory council and directs the advisory council to elicit input from health care providers, health care provider organizations, community and nonprofit groups, insurers, consumers, businesses, school districts, and state and local governments in making its recommendations. The bill provides that the advisory council shall submit initial recommendations to the director for the prevention and chronic care management initiative no later than January 1, 2009. The recommendations are to address: the organizational structure for the prevention and chronic care partnerships which are regionally based prevention and chronic care delivery systems, and an initial partnership to be used as a pilot; a process for identifying leading health care providers and existing prevention and chronic care resources within partnership regions identified and for consulting with these providers and resources; a prioritization of the chronic conditions for which prevention and chronic care management services shall be provided and a timeline for inclusion of specific chronic conditions in the initiative; a method to involve health care providers in identifying eligible patients, which includes the use of a uniform health risk assessment; the methods for increasing communication between health care providers and patients; protocols and tools to be used by health care providers; the use and development of process and outcome measures to provide performance feedback for health care providers and information on the quality of care; payment methodologies to align reimbursements and create financial incentives and rewards for health care providers to utilize prevention services, establish management systems for chronic conditions, improve health outcomes, and improve the quality of care; methods to involve public and private groups, health care providers, insurers, third=party administrators, associations, community and consumer groups, and other local entities to facilitate and sustain the initiative; alignment of any information technology needs with other health care information technology initiatives; methods to involve appropriate health resources and public health and outcomes researchers to develop and implement a sound basis for collecting data and evaluating the clinical, social, and economic impact of the initiative; elements of a marketing campaign that provides for public outreach and consumer education in promoting prevention and chronic care management strategies among health care providers, health insurers, and the public; and a method to periodically determine the percentage of health care providers who are participating, the success of the empowerment of patients approach, and any results of health outcomes of the

patients participating.

The bill directs the director of human services to obtain any federal waivers or state plan amendments necessary to implement the prevention and chronic care management initiative within the medical assistance, hawk=i, and IowaCare populations.

The bill directs the director of public health, following the submission of the initial recommendations by the advisory council, to select one or more regions for deploying and evaluating prevention and chronic care partnerships pilot projects. Following deployment of the initial pilot project, the director shall work with the department of human services, insurers, health care provider organizations, and consumers in implementing the initiative beyond the population of eligible individuals as an integral part of the health care delivery system in the state. The advisory council is directed to continue to review and make recommendations to the director regarding improvements in the initiative.

The bill also specifies requirements for each prevention and chronic care partnership.

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